STATE OF ALABAMA
DEPARTMENT OF FINANCE
DIVISION OF RISK MANAGEMENT
STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

BLOOD/BODY FLUID EXPOSURE REPORT

NOTE: **It is the responsibility of the employee's supervisor to complete Part I.**
The employee must complete Part II.
The supervisor must submit this form **and** the First Report of Injury form by fax to SEICTF at the time the injury is reported.
FAX: (334) 223-6170 or toll-free: (888) 827-6753
IF QUESTIONS, CALL SEICTF: (334) 223-6162 or toll-free (800) 388-3406

PART I

TO BE COMPLETED BY SUPERVISOR

1. Employee's Name_____
   Last First MI
2. Agency Name_____
3. Date of Incident_____ 4. Time of Incident_____( ) A.M. ( ) P.M.
5. Employee previously vaccinated against Hepatitis B (HBV): ___ No ___ Yes Date:_____
6. Check the route of exposure:
   _____ Needle stick, contaminated
   _____ Needle stick, non-contaminated
   _____ Scratch, skin broken
   _____ Scratch, skin not broken
   _____ Blood on non-intact skin (skin has open area such as scratch, abrasion, acne, dermatitis)
   _____ Blood on intact skin (no open areas)
   _____ Splashing / spraying of blood or other potentially infectious material **
   ** List all known materials_____
   _____
   _____ Other, please describe:
   _____
   _____ Bite, skin broken
   _____ Bite, skin not broken
7. Source of exposure known: _____Yes _____No
   Source tested: _____Yes _____No Date_____

_____ Date_____
Supervisor's Signature

EMPLOYEE MUST COMPLETE PAGE 2 OF THIS FORM

PART II

This section is to be completed by the potentially exposed employee.

Due to contact with blood, body fluid or other potentially infectious material, I understand that I may have been exposed to a bloodborne pathogen. In order to determine if this has happened, it may be necessary to test my blood for HIV (virus which causes AIDS), Hepatitis B virus (HBV), and Hepatitis C virus (HCV). I authorize the health care facility performing the testing, to release the test results to SEICTF and the follow-up SEICTF physician. I understand the results of these tests will be kept confidential and related costs will be paid by SEICTF. I further understand that SEICTF will have no responsibility to provide coverage to any state employee who refuses initial treatment, baseline blood testing, and/or release of test results for HIV, HBV and HCV.

Release of Health Information

I hereby authorize any physician, healthcare professional, hospital or other medical care facility to provide my complete health care records, including all lab results, to representatives of SEICTF, and/or its agents regarding my health and any treatment rendered. The purpose for disclosure of these records is to allow SEICTF to evaluate the patient's medical history and injuries in this claim and to administer benefits the patient may be eligible for under the SEICTF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This Release of Health Information is valid for one year from the date the patient signed this release.

Sign ONE of the following:

A.) I understand the above, have been given the opportunity to ask questions and **agree** to treatment and release of health information.

Print Employee Name	Employee's Signature	Date
Print Supervisor's Name	Supervisor's Signature	Date

B.) I understand the above, have been given the opportunity to ask questions and **REFUSE** medical treatment understanding that I am declining my SEICTF benefits for this potential exposure.

Print Employee Name	Employee's Signature	Date
Print Supervisor's Name	Supervisor's Signature	Date